THE RECOVERY KERNEL

Harm Reduction Series — Addendum

THREE UNSPOKEN RULES

Tachyons and the Body in Motion

No Drugs Around Children

The Double Standard, the Two Moralities, and How to Reconcile Them

Three topics that belong together because they share the same underlying structure:

The body that becomes calibrated to a substance state. The child whose nervous system should never be calibrated to one. The relationship that is trying to run two incompatible rule systems simultaneously.

All three are about what happens when the system is designed around something it should not be designed around — and how to redesign it honestly.

PART I

TACHYONS

The Proprioceptive-Motor System and Its Calibration to Substance States

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I.1 — What JR Token Is Naming

THE CENTURION — This Is Not Just Reflexes and Impulses. The Body Has Physics. That Physics Gets Groomed.

JR Token's concept of 'tachyons' points to something that the standard addiction literature almost entirely misses: the body's movement physics — the proprioceptive sense of trajectory through space, the vestibular calibration of balance and orientation, the cerebellar prediction of the sensory consequences of motion — can become specifically calibrated to a substance state over time through exactly the kind of neuron growth and grooming that produces all skilled movement.

This is distinct from the standard addiction story. The dopamine circuit tells the story of wanting and reward. The tachyon system tells a different story: the story of a body whose physics have learned to feel correct in a specific neurochemical state — and feel subtly wrong, disoriented, or incomplete when that state is absent.

The person who has always danced on MDMA, always run on cannabis, always worked out on stimulants, always navigated space under the specific neurochemical signature of their substance — has developed a movement system calibrated to that signature. The sober state is not merely less pleasurable. It is a different physics. A different proprioceptive world. And the nervous system, which above all things prefers the state it knows as normal, creates a specific pull back toward the calibrated state.

I.2 — The Neurological Systems Involved

System	What it does and why it matters for substance calibration	What chronic substance exposure does to it
The Cerebellum — 'the behind-the-ear region'	The cerebellum coordinates all movement by generating predictions of the sensory consequences of motor commands. When you reach for a glass, the cerebellum predicts exactly how the arm should feel as it extends and what it should feel when it contacts the glass. Any mismatch between prediction and reality generates an error signal that refines the movement. CB1 receptors (cannabis) are among the densest in the cerebellum. GABA receptors (alcohol, benzodiazepines) are abundant. The cerebellum is extremely pharmacologically sensitive.	The cerebellum's prediction models are calibrated to the pharmacological state present during their formation. If movement sequences are consistently practiced under cannabis, the cerebellar prediction models are built to match the cannabis-state proprioceptive signature. In the sober state, the same movements generate mismatch errors — the predictions were built for a different body chemistry. Chronic alcohol specifically: Purkinje cell loss and cerebellar cortex atrophy produce permanent gait ataxia — the wide-based, unsteady gait of long-term alcoholism is cerebellar damage. Purkinje cells do not regenerate.
The Vestibular System — the inner ear and its brainstem connections	The vestibular system computes orientation in three-dimensional space — up/down, forward/back, side/side, rotation. It integrates with the visual system and the	Long-term alcohol use can produce permanent vestibular dysfunction — the permanent sense of imbalance and difficulty with complex environments that some

	proprioceptive system (sensors in muscles and joints) to produce the unified sense of where the body is and where it is going. Alcohol specifically enters the inner ear fluid (endolymph), changing its density and altering the semicircular canals' response to head movement. This is why spinning feels different drunk — the otolith organs and semicircular canals are literally in a different physical environment.	recovering alcoholics carry for life. Cannabis use alters vestibular processing, particularly the integration of vestibular and visual signals. Long-term heavy users show measurable changes in vestibular-visual integration in fMRI studies — the body's sense of orientation is processed differently.
The Basal Ganglia — procedural movement learning	The basal ganglia learn and automate movement sequences — the procedural memory of how to perform skills. When you first learn to ride a bike, the prefrontal cortex is heavily involved. After practice, the basal ganglia take over and the movement becomes automatic. The basal ganglia are heavily dopaminergic — they are the primary addiction circuit's movement interface.	The procedural movement patterns encoded in the basal ganglia are encoded in a specific dopaminergic context. High dopamine (from stimulants, MDMA, opioids) produces stronger reinforcement of the movement sequences being performed — the basal ganglia literally learns movement patterns more powerfully when dopamine is elevated. This means movements practiced under substance influence are more strongly encoded than the same movements practiced sober.
The Frontal Motor Areas — prefrontal-motor integration	The supplementary motor area (SMA), the premotor cortex, and the motor cortex in the frontal lobe plan and execute voluntary movement. The prefrontal cortex provides the intentional and contextual direction for movement — 'I am going to do X because of Y.' Impairments to these areas alter the quality of intentional movement.	Chronic alcohol produces frontal lobe atrophy beyond cerebellar atrophy — the movement planning areas are also damaged. The specific impairment: movements become less intentional, more reactive, less adaptable to novel situations. The person moves on ingrained patterns rather than flexibly adapting.

I.3 — The Grooming Phenomenon: How the Tachyon System Becomes Substance-Dependent

JR Token's word 'grooming' is precise. Synaptic pruning and growth — the biological processes by which the nervous system refines its own connections — are experience-dependent. The connections that are used grow stronger. The connections that are unused are pruned. This is the mechanism of skill development, of habit formation, of expertise. It is also the mechanism by which the substance-calibrated movement system develops.

How normal motor grooming works	How substance-calibrated motor grooming works
A person learns to ski. In the first year, every movement is deliberate and effortful — prefrontal-cortex-dependent, slow, cognitively costly. Over seasons of practice, the movement sequences move from prefrontal to cerebellar and basal ganglia control. The expert skier's movements are automatic, fast, and require minimal conscious attention. The movements were groomed into the hardware. This grooming is specific to the conditions of practice: the expert skier who always trained on powder is slower on ice. The expert dancer who always trained on hardwood is less comfortable on sprung floor. The grooming is for the specific context.	A person who consistently performs physical activities — dancing, training, working, driving, navigating environments — in a specific substance state has their movement system groomed in that pharmacological context. The cerebellum's prediction models include the substance's neurochemical signature as part of the normal context. The vestibular calibration is built for the substance-altered state. The basal ganglia's procedural encoding was strengthened by the elevated dopamine during substance use. Result: the movement system functions with a specific quality in the substance state (the groomed state) that it does not achieve in the sober state (the ungroomed state for this person's actual movement patterns). The person moves better, feels more natural, experiences more physical flow in the substance state than the sober state. This is a genuine and specific reinforcement for continued substance use that operates independently of the reward/pleasure circuit.

I.4 — The Tachyon Dependency: A Different Kind of Craving

Most recovery frameworks address the dopamine craving — the wanting, the reward-seeking, the pleasure-anticipation that drives return to use. The tachyon system produces a different kind of pull: the pull of physical normalcy. The body that has been groomed to a substance state does not crave the substance for pleasure. It experiences the sober state as physically incomplete — as a wrong

physics, a misaligned proprioceptive world — and the substance as the restoration of normal.

What the person experiences	What is neurologically happening	Why this is harder to treat than reward craving
'I just feel more like myself when I'm using.' Not more high, not more pleasured — more like themselves. More physically coherent. More physically natural. The sober state feels like a slightly foreign body that doesn't quite move the way it should.	The cerebellar prediction models generate mismatch errors in the sober state because the predictions were built for the substance-state proprioceptive signature. The vestibular calibration produces low-level disorientation in the sober state. The movement sequences encoded by the basal ganglia under elevated dopamine feel effortful and incomplete without that dopamine context.	The reward craving responds to dopaminergic support, to natural reward development, to the transplantation framework, to BDNF-building exercise. These rebuild the wanting for natural reinforcers. The tachyon dependency is a different system — it requires time in the sober state for the movement system to recalibrate. The recalibration takes months of consistent sober physical activity. The discomfort during recalibration is real and is a genuine withdrawal experience that the standard recovery framework does not adequately name or address.

I.5 — Recovery Protocol for the Tachyon System

THE CENTURION — The Recalibration Requires Using the Movement System in the Sober State Until the Sober State Becomes the Calibrated State.

The treatment for tachyon dependency is time and consistent sober physical engagement. The cerebellum's prediction models update continuously based on experienced prediction errors. The vestibular system recalibrates with consistent exposure to the sober neurochemical state during movement. The basal ganglia's procedural encoding is not erased — it is supplemented by new sober-state encoding until the sober movement patterns become equally or more fluent.

- Consistent daily physical activity in the sober state — specifically the activities that were previously performed in the substance-calibrated state. The dancer who always danced on MDMA needs to dance sober, repeatedly, through the initial discomfort of the uncalibrated movement system.

- The discomfort period is predictable: approximately 2-6 weeks of regular sober practice in the specific activity before the sober movement quality begins to approach the substance-calibrated quality. The brain needs enough sober-state practice to build new cerebellar prediction models and new basal ganglia procedural sequences.
- BDNF support accelerates recalibration: the brain-derived neurotrophic factor produced by cardiovascular exercise supports the synaptic plasticity that the recalibration requires. The exercise that produces BDNF also facilitates the cerebellar and basal ganglia adaptation to the new state.
- The specific insight from the Recovery Kernel's dance guide applies: learning to move sober is learning. The initial awkwardness is not the sober self — it is the uncalibrated sober self. The calibrated sober self requires practice to reach. The person who tried once sober and concluded 'I can't do this without the substance' made the comparison at Week 1, not at Week 8.
- Music without substance (the behavioral addiction guide's music-while-exercising section): the person whose movement system is calibrated to substance states AND calibrated to music may need to recalibrate both simultaneously. The music-free physical practice rebuilds the intrinsic proprioceptive feedback loop that both substance use and music masking had overridden.

SANCTUARY — The tachyon system recovers. The cerebellum retains neuroplasticity in most substance classes (with the exception of severe chronic alcohol, which produces permanent Purkinje cell loss). The movement physics of the sober state can become the groomed state — but only if the sober state is practiced with the same consistency that the substance state was.

PART II

NO DRUGS AROUND CHILDREN

The Non-Negotiable Rule and Why Every Dimension of It Matters

II.1 — The Absolute Rule

⚠ This is the only absolute rule in the entire Recovery Kernel harm reduction series. Not a strong recommendation. Not a high priority. Absolute.

No substance use around children. The rule is not nuanced by substance type, dosage level, frequency, or the adult's subjective assessment of their impairment state. It applies when children are present in the environment, under the adult's care, or accessible to the adult's supervision. It applies even when the adult feels completely functional. It applies even for substances with mild effects at low doses.

Why no nuance here: Every other rule in this series has nuance. The vehicle rule has clearance times. The machinery rule has categories. The social environment has dose ceilings. Children are the exception to the nuance framework because the risk category is different: the harm that can occur when a primary caregiver is impaired in the presence of children can be immediate, severe, and irreversible — and the caregiver's assessment of whether they are impaired enough for this to matter is specifically what the substance impairs.

II.2 — The Five Dimensions of Why

Dimension	The specific risk	Why 'I was only slightly impaired' doesn't change it
1. Safety response capacity	Children require adult emergency response that is immediate, accurate, and competent. The child who chokes, the toddler who falls, the infant who stops breathing, the older child who runs into the street — these emergencies require a response in seconds with full cognitive and motor capacity. Substance impairment reduces reaction	The 200ms reaction time delay from cannabis. The impaired assessment of emergency severity from alcohol. The cardiovascular impairment that reduces the adult's physical response capacity from stimulants. Children's emergencies do not wait for the impairment to clear.

	time, decision quality, and physical response capacity.	
2. Accidental child exposure to substances	Children are specifically at risk of accidental ingestion of substances left accessible in an environment where the adult is using. Cannabis edibles that look like regular food. Pills that look like candy. Liquid substances accessible on surfaces. The impaired adult's management of substance storage is specifically degraded by the impairment.	Cannabis edible ingestion is the leading substance exposure incident in pediatric emergency rooms in states where cannabis is legal. These incidents occur most frequently when an adult has been using in the presence of children and the storage discipline that sober judgment would apply was reduced.
3. Secondary exposure	Secondhand smoke (tobacco, cannabis) is established as harmful to children. Infants and young children are particularly vulnerable because their respiratory systems are still developing and because they spend more time in enclosed spaces. Cannabis smoke contains many of the same carcinogenic compounds as tobacco smoke.	There is no safe level of secondhand smoke exposure for children. The adult who 'only smokes outside' in a home with children is improving but not eliminating the exposure — smoke enters through ventilation, on clothing, in the adult's hair and on their skin.
4. The modeling effect — what children learn to expect	Children develop their understanding of what adult behavior looks like and what normal household patterns are from what they observe. The adult who uses substances regularly in the presence of children is providing the child's baseline model for what adults do. Normalized substance use in the home is the single strongest predictor of earlier substance use initiation in children.	This is not about the single incident. It is about pattern. The child who grows up in a home where substance use is ambient and unremarkable inherits that baseline as their normal. The DNA First framework identifies the genetic vulnerabilities — but the social baseline is the environment that activates them. Genetic risk + normalized early exposure is the highest-risk combination.
5. The trust architecture	Children's relationship with the adult world is built on the reliability and safety of specific adults. The caregiver who is unpredictably impaired, who has episodes of altered behavior that the child experiences as frightening or	The child does not need to know what a substance is to experience the impairment's effects on the caregiver relationship. Infants detect the altered behavioral patterns of an intoxicated caregiver. Toddlers develop

	confusing, who is emotionally and cognitively different in ways the child cannot understand — produces attachment insecurity in exactly the form that is the highest risk factor for the child's own future substance use and mental health outcomes.	hypervigilance in response to parental unpredictability. Older children carry the specific worry of the caregiver who cannot be relied upon. This is ACE (Adverse Childhood Experience) exposure — it rewires the developing nervous system.

II.3 — The Practical Protocol

The rule is absolute. The protocol is the structure that makes the rule livable:

- Time-designated use windows: substance use occurs only during windows when the child is not present and will not return before clearance. The child at school from 8am-3pm and the adult who uses at 10pm after the child is asleep are both windows that do not violate the rule. The child who might wake up at 3am is a child whose parent should not be at peak impairment at 3am.
- Designated sober caregiver: when any adult in the household uses substances, another sober adult assumes primary caregiver responsibility. This is not a burden to the other adult — it is a rotation. It requires explicit communication and explicit agreement.
- Substance storage that a child cannot access: locked, in a dedicated container, at height inaccessible to the child's current developmental stage. Not in the same cabinet as food. Not in unmarked containers. The test: if I came home to find the child alone for 15 minutes, would they have access to my substances? If yes, the storage is not adequate.
- Cannabis-specific edible management: cannabis edibles are stored differently from all other food. Not in the fridge. Not in the pantry. Locked. The packaging that makes them look like regular candy or food is the specific risk that requires the most rigorous storage management.
- The conversation with older children: children old enough to understand deserve age-appropriate honesty. 'This is something adults sometimes use, and it is not safe for children' is a complete and appropriate statement. The alternative — modeling use as normal without explanation — is more normalizing than any honest conversation would be.

II.4 — The Cannabis-Caregiver Specific Problem

Cannabis is experiencing legalization and normalization at the same moment that its use is expanding among parents of young children. The specific cannabis-caregiver scenarios that require explicit address:

- The caregiver who uses cannabis for anxiety, sleep, or pain management: the therapeutic framing does not change the impairment reality. The parent whose cannabis use is medically supervised still experiences the cannabis-state proprioceptive alteration, the delayed reaction time, and the altered judgment that the substance produces. Therapeutic use requires the same time-designated window and designated sober caregiver approach.
- 'I'm a better parent when I'm high': this is the most common cannabis-parenting rationalization, and it deserves direct engagement. The parent feels more patient, more present, more creative. What the child experiences is a parent whose response latency is increased, whose emotional attunement is altered, and whose emergency response capacity is reduced. The subjective improvement in patience does not correspond to an objective improvement in parenting capacity.
- The baby-asleep exception: 'I only use after the baby is asleep.' The baby who sleeps through the night 95% of nights is the baby for whom the parent needs to be immediately capable on the 5% night when something is wrong. The infant respiratory emergency, the high fever, the fall from the crib — these are the events the sleeping-baby exception fails to account for.

PART III

THE DOUBLE STANDARD

Two Sets of Rules, Two Moral Frameworks, One Collapsing System

And the Adderall XR That the Dealer Also Sells

III.1 — The Cognitive Architecture of Maintaining Two Moral Frameworks

THE CENTURION — Keeping Track of Two Incompatible Rule Systems Requires Cognitive Resources. Those Resources Come From Somewhere. They Come From You.

The double standard — 'you can't use but I can' — is not simply a relational unfairness, though it is that. It is a specific cognitive and psychological load that the person applying the double standard carries continuously. Maintaining two incompatible rule systems requires active cognitive work: tracking which framework applies to whom, suppressing the awareness of the contradiction, generating justifications for the asymmetry, monitoring whether the other person is observing the contradiction.

Leon Festinger's theory of cognitive dissonance (1957) describes the psychological discomfort of holding two contradictory beliefs simultaneously. The theory predicts that the discomfort drives one of three responses: changing one of the beliefs, adding justifications that make the contradiction appear non-contradictory, or reducing engagement with the belief that produces the contradiction. In the double standard context: the person either changes the rule (applies it to themselves too), adds justifications ('mine is different because...'), or reduces their engagement with the moral dimension of their own use ('I don't think about it').

Double standard type	The cognitive load it produces	The psychological consequence over time
'You can't use but I can' — partner/spouse asymmetry	Constant monitoring of the partner's behavior for compliance with the rule that does not apply to the self. Generating justifications for the asymmetry when questioned. Suppressing the recognition of unfairness when it surfaces. Tracking two moral frameworks for the same household	The partner who is prohibited from using while watching the prohibiting partner use experiences the prohibition as contempt rather than care. The prohibiting partner experiences escalating anxiety about the sustainability of the asymmetry and increasing cognitive resources devoted to its

	context.	maintenance. The relationship develops a specific power dynamic organized around moral hypocrisy.
'I have a prescription but I'm also buying from my dealer' — the dual-supply pharmaceutical scenario	Tracking the legitimate prescription behavior separately from the supplemental illegal behavior. Managing the physician relationship while withholding the information that would be most relevant to the physician's prescribing decision. Maintaining a public health-system identity and a private supply chain behavior simultaneously.	Escalating anxiety about the physician relationship. Escalating anxiety about the legal risk of the supplemental supply. The specific dissonance of believing 'I know better than my doctor about what I need' while simultaneously relying on the doctor's prescription for the legitimate baseline. The risk of losing the prescription if discovered increases with the duration of the dual-supply arrangement.
'My drug use is responsible but theirs is a problem' — the substance hierarchy double standard	Creating and maintaining a taxonomy of 'acceptable' and 'unacceptable' drugs that conveniently places one's own use in the acceptable category and the partner's or child's use in the unacceptable category. This taxonomy requires ongoing rationalization because it is based on preference rather than evidence.	The rationalization of why alcohol (or cannabis, or prescription stimulants) is categorically different from the partner's substance requires continuous mental energy. The rationalization breaks down under any close examination, which the person therefore avoids. The avoidance of examination becomes the maintenance mechanism for the double standard.

III.2 — The Adderall XR Scenario — Full Analysis

The specific scenario JR Token names: 'I have a prescription for Adderall XR but I also buy extra Adderall XR from my dealer since my doctor won't increase the dose.'

This is among the most common pharmaceutical-adjacent dual supply situations. It deserves honest, specific analysis without judgment — because it is both medically interesting and legally and psychologically complex.

Dimension	What is actually happening	The honest implications
The dose adequacy question	The person with a prescription who supplements from an unlicensed source is implicitly	The most direct resolution: have the explicit conversation with the prescriber about

	communicating that the prescribed dose is not achieving the therapeutic goal. This is a real clinical issue: ADHD medication optimization often requires dose adjustment, and some prescribers are conservative in a way that leaves patients therapeutically under-dosed.	therapeutic inadequacy at the current dose. 'The current dose is not achieving the effect I need for X hours of functional productivity' is a clinical statement that the prescriber needs to hear to make the correct prescribing decision. The prescriber who 'won't increase the dose' may not be receiving the information that would change that position.
The legal risk of the supplemental supply	Possessing Schedule II controlled substances (Adderall, Ritalin, etc.) without a prescription is a federal crime. Purchasing them from an unlicensed source (the dealer) is also criminal — for both parties. The person who is caught with prescription Adderall that exceeds their prescription amount faces specific legal exposure even with a valid prescription for a lower dose.	The legal risk is asymmetric: the prescription provides no legal protection for the amount above the prescription. The person arrested with 60 Adderall XR who has a prescription for 30 is not protected by the prescription for the additional 30. The dealer relationship that provides the supplement is an independent legal risk for the buyer.
The physician relationship risk	If the physician discovers (through any mechanism — urine drug screen showing higher amphetamine metabolite levels than the prescribed dose should produce, pharmacy monitoring programs, insurance investigations) that the patient is using above the prescribed dose, the physician has both legal and professional motivation to terminate the prescription.	The loss of the prescription eliminates the legitimate portion of the supply and leaves the person dependent entirely on the unlicensed source. The risk calculus: the supplemental use that felt like solving the inadequacy problem could produce the loss of the legitimate access entirely.
The tolerance and dose escalation dynamic	Amphetamine tolerance is real. The dose that was therapeutic at the start of treatment requires escalation over time for many patients. The person who supplements from an unlicensed source is dose-escalating outside the medical supervision structure that exists specifically to manage	The person who has dose-escalated on supplemental Adderall XR to a level significantly above the prescribed dose has developed tolerance that their physician is not aware of. If the supplemental supply is cut off and they are left with the prescribed dose, they may

	this escalation safely.	experience a relative withdrawal from a dose their body has calibrated to. This is a medically relevant situation that is not being managed.
The cognitive dissonance cost	The ongoing tracking of the legitimate prescription behavior vs. the supplemental behavior, the management of the physician relationship while withholding the relevant information, the anxiety about the legal and professional risks — all of these are cognitive and psychological loads that are themselves incompatible with the ADHD treatment goal.	The Adderall is being taken to address the cognitive challenges of ADHD. The cognitive load of managing the dual supply reduces the net cognitive benefit of the medication. The solution that was supposed to improve executive function is being maintained through an arrangement that specifically taxes executive function.

III.3 — How to Reconcile the Double Standards

THE CENTURION — The Framework That Works Is One Framework. Not One for You and One for Everyone Else. One.

Reconciliation means arriving at a position that is consistent and that does not require ongoing cognitive management to maintain. There are two paths to reconciliation — and only two:

Path 1: Apply the rule universally	Path 2: Remove the rule for the other person
If the rule is 'no cannabis use in the household,' apply it to yourself as well. If the rule is 'prescription use only, no unlicensed supplements,' apply it to yourself as well. If the rule is 'no use around children,' apply it to everyone equally. The universal rule is cognitively costless: there is no tracking required, no justification required, no monitoring of exceptions. The rule either applies or it doesn't, and it applies the same way to everyone.	If the rule cannot be applied universally — if you are going to use regardless — then the honest position is removing the prohibition from the other person rather than maintaining a double standard. This is not the same as having no values about use. It is the honest position that 'I am not in a position to set this rule for you while I do not follow it myself.' The relationship can still have agreements about where, when, and around whom use occurs — but those agreements must be mutual.

III.4 — Reconciling the Prescription + Supplemental Supply

The honest resolution of the Adderall XR scenario has three components, in order:

1. Have the therapeutic inadequacy conversation with the prescriber. Specifically: 'My current dose of Adderall XR is providing X hours of productive function, and I need Y hours. The dose is not achieving the therapeutic goal.' Document this conversation. If the prescriber still declines to adjust, ask for a referral to a psychiatrist who specializes in ADHD pharmacotherapy. Dose optimization is a legitimate medical goal and a second opinion is appropriate.
2. If the supplemental supply continues while pursuing the legitimate dose adjustment: acknowledge honestly that you are carrying a legal risk and a physician-relationship risk that are not justified as a permanent solution. This is harm reduction self-awareness: the behavior has consequences, you are choosing to accept those consequences temporarily while pursuing the legitimate path. That is a different cognitive position than pretending the risks don't exist.
3. When the dose conversation with the physician succeeds and the legitimate dose is adequate: end the supplemental supply immediately. The supplemental supply that continues after the legitimate dose is adjusted is no longer about therapeutic adequacy — it is about dose escalation beyond what is medically supervised. This is a different situation and a different risk profile.

III.5 — The Relationship With the Two Rules

For the partner double standard specifically — the 'I use but you can't' arrangement — the reconciliation requires honesty about what the rule is actually for. Rules about substance use in relationships serve three possible functions:

- Safety (protecting children, protecting driving, protecting income stability): these rules are legitimate and should be applied universally — to both partners equally. Any safety-based rule that is applied asymmetrically is not actually about safety.
- Health (concern for the partner's physical wellbeing): this is also a legitimate motivation, and it is most honestly expressed as concern rather than prohibition. 'I'm worried about your use' is a different communication from 'you can't use.' The concern doesn't require the prohibition, and the prohibition without the concern expressed doesn't serve the health goal.
- Control: the 'you can't use but I can' rule that is based neither on safety nor on health is a control rule. It is using the moral authority that one person has claimed over the other's behavior to manage the power dynamic of the relationship. This is the most important function to identify honestly, because the justifications will sound like safety and health while actually serving the control function.

The question to ask: if the partner changed the substance they use to the one I use, would the rule still apply? If yes, the rule is about the behavior. If no, the rule is about the substance — and the asymmetry about substances reveals whether the rule is principled or preferential.

The Three Unspoken Rules — Summary

THE CENTURION — The Body Needs a Sober State to Recalibrate To. The Child Needs a Sober Caregiver. The Relationship Needs One Set of Rules.

THE THREE RULES — COMPACT FORM

THE TACHYON SYSTEM: If your body has been groomed to move in a substance state, the sober state will feel like wrong physics for a period. This is not a permanent state — it is an uncalibrated state. The recalibration requires consistent sober physical practice in the activities where the substance was previously the operating state. It takes weeks. It is not pleasant. It works.

CHILDREN: No drugs around children. No exceptions. No dose levels that are 'fine.' No impairment-state assessments made from inside the impairment. The rule is absolute because the risk category is absolute — the child's emergency does not pause for the clearance time.

THE DOUBLE STANDARD: One rule framework, applied to everyone in the household equally. The rule that cannot be applied universally is a rule that should not be applied at all. The prescription + supplemental supply is a temporary arrangement in pursuit of the legitimate dose, not a permanent operating position. The conversation with the prescriber is the resolution.

All three are about the same thing: what the system is designed around. The body should not be primarily designed around the substance state. The child's household should not be designed around the parent's use schedule. The relationship should not be designed around an asymmetric moral architecture that one person is maintaining at a cognitive cost they are paying every day.

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Recovery Kernel | Three Unspoken Rules | Harm Reduction Addendum
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The sober state is a state worth calibrating to. It is not the absence of the substance state. It is its own physics.